EXHIBIT A

Excerpts from the Depositions of:

Babu Rao Paidipalli, M.D.

*

Mark P. Clemons, M.D.
and
Exhibit 2 to Clemons Deposition

*

Jason D. Kennedy, M.D.
and
Exhibit 6 to Kennedy Deposition

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF TENNESSEE

DANIEL LOVELACE AND HELEN LOVELACE, Individually, and as Parents of BRETT LOVELACE, Deceased	)	
Plaintiff,	)	
VS.	)	NO. 2:13-cv-02289 dkv
PEDIATRIC ANESTHESIOLOGISTS, PA; BABU RAO PAIDIPALLI and MARK P. CLEMONS ,	)	
Defendants.	)	

DEPOSITION OF BABU RAO PAIDIPALLI, M.D.

January 9, 2014

MIDSOUTH REPORTING SERVICE

LU ANNE R. DUDLEY, CSR, LCR #349
P.O. BOX 1631
CORDOVA, TENNESSEE 38088
(901)525-1022

Aldrete score perfect.

Q Now at the time that Brett Lovelace was extubated, approximately how much time passed between that moment and the time that he would have been transported?

Is that normally five minutes? Or how long is that?

A Can you rephrase the question, please.

Q Yes.

Between the time of extubation of the patient how much time elapsed before he was transported to the PACU?

A We extubated the patient 10:26. And the patient reached the recovery room 10:35, so nine minutes.

Q Is it your testimony that the patient was virtually awake at the time that he was extubated?

A Yes, sir.

Q Okay. As a rule and a practice how often would you allow patients to go and be on their face in recovery?

MR. COOK: Same, form.

Go ahead.

A That is a speculation.

BY MR. LEDBETTER:

Q How often would you allow people to go in that position prone into the PACU at LeBonheur?

MR. COOK: Same.

A Same. I cannot answer that speculative question.

BY MR. LEDBETTER:

Q Well, was it something that happened that you allowed a number of times?

A That is the same thing I said. It is very speculative.

Q Why would it be speculation?

Did you allow patients to go to the recovery room who were in a prone position, or not, before Brett Lovelace?

A We, as long as the patient is not completely prone, but we -- actually, tonsil patients, semi prone is the ideal position for the patient because if there is any bleeding, it will come out. The tongue will also fall out so that they breathe better. That is called post tonsillectomy position.

Q Now in this case do you rely upon any clinical guidelines for anesthesiologists that support your defense in this case?

Do you have any clinical guidelines or ASA texts or standards that you see as relevant?

A Well, we have books that are for reference if we are there, but mostly we go by clinical judgment and our -- you know, that is what we go by, clinical judgment. Because all of these books, it won't pertain to the particular patient. You know, those are all differences.

Q Are you familiar with clinical guidelines for anesthesiologists that deal with patients who have surgery with upper airway problems or morbidities?

A There are guidelines, but it is a clinical judgment to maintain, you know, the airway problems.

Q Well, what clinical guidelines can you cite me to that apply to patients with upper airway problems and the standard of care of an anesthesiologist?

A One of the clinical guides we look at is for the patient to be extubated and is awake. That is the criteria for upper airway obstruction patients.

Q Are you familiar with the guideline that urges caution on the part of an anesthesiologist in the extubation or untimely -- against the untimely

extubation of a patient with upper airway disturbances?

A That is what I'm telling you, sir.

A patient, we extubate those patients awake compared to the patients who are deep. That is the criteria we use, extubation awake.

Q Now at the time of his extubation in the operating room were you aware that Brett Lovelace had experienced hypercarbia or hypercapnia?

A No, sir.

Q When a person suffers asphyxia, is hypercapnia or hypercarbia a coincident occurrence or symptom?

A Hypercapnia is a coincidence. It is a mystery. The patient may be hypo-ventilating for some time.

Q Now at the time that you extubated Brett Lovelace, was he in deep extubation?

A No, sir.

Q Okay. Are you aware that at the time you extubated him that he had pretty small title volumes and inadequate effort?

A No.

My clinical judgment was that the patient was awake, breathing well. And when he opened his

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE

DANIEL LOVELACE AND HELEN LOVELACE, INDIVIDUALLY AND AS PARENTS OF BRETT LOVELACE, DECEASED,	)	
Plaintiffs, VS.	)	2:13-CV-02289dkv
PEDIATRIC ANESTHESIOLOGIST, P. A. BABU RAO PAIDIPALLI, AND MARK P. CLEMONS,	)	
Defendants.	)	

DEPOSITION

OF

MARK CLEMONS, M.D.

February 6, 2014

ORIGINAL

MID-SOUTH REPORTING
Pepper Glenn, CCR
P. O. Box 609
Southaven, Mississippi 38671
(901) 525-1022

we've previously met. And I have passed to you and to your counsel three items which I've proposed to make exhibits to your deposition. The first item is the anesthesia medication record. And do you have that before you?

A. Yes.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 1 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

Q. Okay. Is that a document you have previously seen or you're familiar with?

A. No.

Q. Okay. Do you have any reason to believe that that record is inaccurate or does not apply to this patient?

A. I do not give any of these drugs. I'm not an anesthesiologist. I've never seen this record before.

Q. Okay. Number 2, this is a history of current problems for the patient. And do you identify that as a document that you've created?

A. That is my document.

(WHEREUPON, THE ABOVE-MENTIONED

DOCUMENT WAS MARKED AS EXHIBIT NO. 2 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

Q. Okay. And beneath it, you will see that there are several pages that purport to be an op note or an operatory narrative that you also wrote.

A. Yes, I did.

Q. Okay. And Exhibit Number 3 is a series of photographs that I will represent to you were taken by the parents of Brett Lovelace. And let me ask if you can identify any of the people in the photograph -- in the photograph particularly on the first page. Can you identify that as Brett Lovelace?

A. That is Brett Lovelace.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 3 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

Q. Could you identify who is in the left corner?

A. Do not know.

Q. Could that be his father, Daniel

A. I cannot give it to you because I don't know what the numbers are in the coma scale.

Q. Now, you have -- in Exhibit Number 2 after the first page, Dr. Clemons, you have your op note or your operative report.

A. Correct.

Q. Do you see that?

A. Correct.

Q. Okay. Now, do you know when this was written? I see that the date of service was March 12th, but the date it was signed was March 19th. Do you know when this was written by you or dictated?

A. It probably would have been that day or the next day, the day after surgery. Transcription could tell you that. I don't know.

Q. I think I see it. Turn to the last page and let me ask you --

A. Dictated.

Q. Yeah, it's a D. Does that mean that it was dictated March 12 at 5:48 p.m. or when, 5:48 a.m.?

A. It certainly wasn't 5:48 a.m.

it was -- it was dictated before -- dictated and transcribed before the surgery: is that correct?

A. That's what it says, but it wasn't.

Q. All right. Now, did you ever go back after it was dictated and make any changes to it before it was made a permanent record?

A. Not that I know of, but I'm sure I read it and might have changed a "we" to a -- I change words like "we" to "I," but I couldn't tell you if I changed a word or two.

Q. Well, do you think on the last page, you might have changed the word -- the last sentence from reading, "He tolerated the procedure without problems" to read "He tolerated the procedure itself without problems"? Could you have made that change by adding the word "itself" after he died or after he had problems?

A. Well, when I talk about the procedure, I'm talking about the operative procedure.

Q. Right.

A. We did the surgery. We woke him up, extubated him and took him to the recovery room.

Q. Well, my point is, where it says he tolerated the procedure itself, do you think

A. Supine.

BY MR. LEDBETTER:

Q. Okay. What is that position?

A. They are on their back.

Q. And what is a prone position?

A. On their belly.

Q. Do you know what the Fowler's position is?

A. Well, Semi-Fowler's is sort of a sitting, laying position. I don't know what the Fowler's position is.

Q. Okay. Any reason why Brett was not in a Fowler's position?

MR. GILMER: Object to the form.

A. Well, what is a Fowler's position?

BY MR. LEDBETTER:

Q. I'm asking you if you know what it is.

A. I told you I don't know what a Fowler's position is. I know what Sub-Fowler's is.

Q. But you don't know what the Fowler's position is?

A. No.

* Dr. Clemons will fill out this Side: *

Patient Name: Britt Taylor Date 3-5-14

HISTORY OF CURRENT PROBLEMS:

Ears: _____

Nose: _____

Throat Severe Hoarseness Enlarged Tonsils + Frequent Tonsillitis

Other: _____

_____

PHYSICAL EXAM:

Ears: EAC: WNL

TM: WNL

Nose: WNL

Throat: Tonsils: Enlarged 3+ Cryptic ____ Exudates ____

Erythematous ____

Pharynx: WNL

Tongue: _____

Other: _____

Chest: Clear ✓ Other _____

CV: RRR ✓ Other _____

Abdomen: Soft ___ Other _____

Extremities: Moves all Extremities without problems: ✓

Other: _____

Other findings: _____

ASSESSMENT: T+A question of Enlarged

PLAN: Tests: Blood, X-rays, Other

_____

Meds: _____

_____

Other: _____

Surgery: T ✓ A ✓ PETs ____, Other _____

Follow up: RTC: ____ days, _____ weeks, PRN ____. Parent to call and check on C&S, X-ray, etc _____.

Other: _____

✓ For **tonsillectomy & adenoidectomy**, discussed the risks of anesthesia, bleeding, pain, blood transfusion with the mother & child.

___ For PE tubes discussed the risks of anesthesia, infections, perforated ear drum when the tube comes out, possible need to go back to OR and remove tube if it becomes stuck or infected with _____.

Other: _____

_____

MPC, MD _____

EXHIBIT 2

Le Bonheur Children's Hospital
Methodist Healthcare Family

Le Bonheur
50 North Dunlap
Memphis, TN 38103

Admit Date: 3/12/2012 7:10:00 AM
Discharge Date: 3/14/2012 3:54:00 PM

Name: LOVELACE, BRETT S
MRN: 4585499-4
FIN: 68859557
DOB: 8/21/1999
Age: 12 years
Sex: Male
Location: 8L05/01/A0
Patient Type: Inpatient
Chart Provider: Clemons, Mark P, MD

Transcribed Documents

Document Type: Operative Report
Signed Date: 3/19/2012 7:54:46 AM
Date of Service: 3/12/2012 6:10:00 PM
Author: Clemons, Mark P, MD
Document Status: Auth (Verified)

DATE OF SURGERY: 03/12/2012

PREOPERATIVE DIAGNOSIS
Tonsillar and adenoidal hypertrophy with upper airway obstruction.

POSTOPERATIVE DIAGNOSIS
Tonsillar and adenoidal hypertrophy with upper airway obstruction.

OPERATION
1. Tonsillectomy.
2. Adenoidectomy.

ATTENDING SURGEON
Dr. Mark Clemons.

ANESTHESIA
General with endotracheal (ET) tube.

ESTIMATED BLOOD LOSS
250 mL.

DESCRIPTION OF PROCEDURE
The patient was placed on the operating table in the supine position and anesthetized using general anesthesia. Endotracheal tube was placed. Sterile drapes were placed. A Crowe-Davis mouth gag was inserted into the patient's mouth and was suspended from the Mayo stand. Catheter placed through his nose and used to retract the soft palate.

Le Bonheur Children's Hospital
Methodist Healthcare Family

Le Bonheur
50 North Dunlap
Memphis, TN 38103

Admit Date: 3/12/2012 / 7:10:00 AM
Discharge Date: 3/14/2012 / 3:54:00 PM

Name: LOVELACE, BRETT S
MRN: 45854994
FIN: 68859557
DOB: 8/21/1999
Age: 12 years
Sex: Male
Pt Location: 8L05/01/A0
Patient Type: Inpatient
Chart Provider: Clemons, Mark P, MD

Transcribed Documents

Document Type: Operative Report
Signed Date: 3/19/2012 7:54:46 AM
Date of Service: 3/12/2012 6:10:00 PM
Author: Clemons, Mark P, MD
Document Status: Auth (Verified)

The adenoid pad was visualized and found to be very large and obstructing the airway. Tonsils were very large as well. Using an adenoid curette, multiple passes were made removing a large amount of adenoid tissue. A saline-soaked sponge was placed in the nasopharynx. The right tonsil was grasped with straight Allis and retracted medially. A 12 blade was used to incise the mucosa. Hurd dissector and Fischer knife were used to dissect the tonsil free and amputate the base with snare.

A saline-soaked sponge was placed in the fossa. This was removed and adequate hemostasis achieved using suction cautery. Sponges were placed in the fossa. The left tonsil was removed in a similar manner; however, this was removed in several pieces. Adequate hemostasis achieved using 3-0 plain interrupted suture in the inferior mid fossa as well as suction cautery.

The nasopharyngeal packs were removed. The nasopharynx was examined. A significant amount of adenoid tissue was still remaining in the posterior choanal region and area proximal to the nose. Using adenoid curettes and suction cautery, the tissue was removed opening up the posterior choanae. A saline-soaked sponge was placed back in the fossa. Marcaine 0.25% with epinephrine 1:200,000 was injected in both tonsillar fossae. A total 6 mL was used.

A catheter was run down the patient's mouth into his stomach removing stomach fluid. The nasopharyngeal pack was removed. Adequate hemostasis was achieved using a small amount of additional suction cautery. All instruments were removed. The patient was awakened from anesthesia, extubated, and

Le Bonheur Children's Hospital
Methodist Healthcare Family

Le Bonheur
50 North Dunlap
Memphis, TN 38105

Admit Date 3/12/2012 7:10:00 AM
Discharge Date: 3/14/2012 3:54:00 PM

Name: LOVELACE, BRETT S
MRN: 45854994
FIN: 68859557
DOB: 8/21/1999
Age: 12 years
Sex: Male
Pt Location: 8L05 01/A0
Patient Type: Inpatient
Chart Provider: Clemons, Mark P, MD

Transcribed Documents

Document Type: Operative Report
Signed Date: 3/19/2012 7:54:46 AM
Date of Service: 3/12/2012 6:10:00 PM

Author: Clemons, Mark P, MD
Document Status: Auth (Verified)

taken to recovery. He tolerated the procedure itself without problems.

(E-signed on 03/19/12 at 07:54 AM)

Clemons, Mark P, MD

D: 03/12/12 05:48 T: 03/12/12 06:10 (SC)

Exhibit 2 to Deposition of Mark P. Clemons, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION
- - - - - -

DANIEL LOVELACE, and HELEN LOVELACE, Individually, and as Parents of BRETT LOVELACE, deceased,

Plaintiffs,

vs.

PEDIATRIC ANESTHESIOLOGISTS, P.A.; BABU RAO PAIDIPALLI; and MARK P. CLEMONS,

Defendants.

CERTIFIED COPY

No. 2:13-cv-02289-SHL-dkv

VIDEOTAPED DEPOSITION OF:

JASON D. KENNEDY, M.D.

NASHVILLE, TENNESSEE

WEDNESDAY, JUNE 25, 2014

ATKINSON-BAKER, INC.
COURT REPORTERS
(800) 288-3376
www.depo.com

REPORTED BY: IVA L. TALLEY, LCR
FILE NO.: A80609D

Q Now, between -- what did you do to prepare for your deposition the first time it was scheduled?

A The same series of events. I reviewed the available records that I had received, including the depositions. I had went back and reviewed what the current standards of care are within the anesthetic practice of patients undergoing anesthetics, specifically with sleep apnea, and I had reviewed specifically that in relationship to pediatric patients.

Q Where did you review something concerning what the standards of care were regarding pediatric anesthesia in this particular case?

A Multiple sources, including -- I think it's called -- there's a textbook. There's Miller's Anesthesia, which is a general anesthesia textbook, but it has sections about pediatric anesthesia. It's written by experts in pediatric anesthesia. And then there's two or three pediatric-specific textbooks.

Q Which textbooks are those?

A I would have to get back to you. I can't remember the name right offhand.

Q Prior to reviewing Miller's and those other three -- which I would ask that you supplement

Q And in addition to this expert witness report that we have here, what other records and notes have you made in this case?

A I've got just a couple of things I wrote down here this morning when I was looking at -- that's Smith's, Smith's Anesthesia. That's one of the other books that I have.

Q Okay.

A And that's really it.

Q Let me see that.

A Here, that's about all I've got.

(Witness passes document to counsel.)

BY MR. GILMER:

Q Was this something that you pulled from the internet?

A This is something I pulled off of -- we have digital textbooks. No one makes textbooks anymore because it's just a lot of wasted trees. So all of our textbooks are now computerized, so I just pulled this off, this textbook, that is considered probably -- I won't say the authoritative textbook on pediatrics, but one of the authoritative textbooks on pediatrics.

Q And do you believe that the information contained in this text is authoritative and reliable?

A I believe it's reliable, and it's an

often-referenced opinion by practicing pediatric anesthesiologists.

Q Do you believe it establishes what the standard of care is for pediatric anesthesiologists?

A I think it helps to establish the standard of care. The standard of care is associated with a lot of different things.

MR. GILMER: Let's mark this as our next exhibit, please.

MR. LEDBETTER: No objection.

(Document entitled "Smith's Anesthesia For Infants and Children, Eighth Edition," marked Exhibit No. 4 to this deposition.)

(Off the record.)

MR. GILMER: I did want to clarify one thing on the record. Mr. Ledbetter made a statement about receiving a notice seven days prior to the expiration of a deadline.

BY MR. GILMER:

Q This -- the original notice to take your deposition was filed on May 22nd and contained the same list of items that I have today. Did you see the original notice?

A I honestly don't know.

MR. JOHNSON: That's the pre-pink eye.

THE WITNESS: Yeah.

BY MR. GILMER:

Q Let's mark the original notice as our next exhibit, please.

(Notice to Take Audiovisual Deposition of Dr. Jason Kennedy filed May 22, 2014 marked Exhibit No. 5 to this deposition.)

BY MR. GILMER:

Q Now, the text that you pulled to review in this case -- when did you pull this?

A I just happened to pull it this morning just before I walked over here.

Q In addition to this Smith's Anesthesia section that you have here marked as Exhibit 4, what other notes and records did you generate with respect to this case?

A I think I jotted down a couple of things on paper, but I don't remember where they are at right now.

Q Do you still have those things?

A They are probably at my -- either at my home office or in my office over here.

Q Okay. I would ask that you -- subject to plaintiff's objection, I would ask that you preserve those and not destroy that evidence because we may be

entitled to that down the road.

A Okay.

Q The notes that you made, what did they say?

A Mostly, I was trying to develop a time line of what happened. And then I -- that's kind of -- I was trying to figure out through digging through all those record-s, because it's quite voluminous, and I was just trying to find out what were the course of events.

Q Were you able to put together what you thought was the course of events?

A I was able to piece together, as best as I could.

Q What other notes and records did you generate besides that?

A That's probably about it.

Q Okay. Did you communicate with Mr. Ledbetter via email?

MR. LEDBETTER: Objection to questions concerning communication under Federal Rules. They pertain to expert witnesses. You're not allowed to get into communications unless they are under certain circumstances, and your question does not address those circumstances.

BY MR. GILMER:

Q Did Mr. Ledbetter give you any facts or opinions related to this case before you formulated your opinions in the case?

A No, he didn't.

Q What did he provide you with originally so that you could form your opinions?

A I think he just sent me the copy of records from Le Bonheur Children's Hospital, and that's it.

Q And then at separate times, did he then send you the depositions as they were completed?

A Yeah. That was quite a bit later.

Q But he did not send you the parents' depositions?

A I don't recall seeing those.

Q Did you know the parents were in the PACU during the entire time that this -- that the child was there?

A I remember seeing something to that effect that for a good portion of the time that the parents were there. I didn't know if it was all or just part of it.

Q Did you see the pictures that they took?

A I did.

Q That's fine. Have you reviewed any specific guidelines from the hospital itself regarding their policies and procedures?

A I remember asking for one when I first saw this for their PACU care. And I remember -- I think I remember reviewing it, but that's been, like I said, over a year ago. And, basically, I think what I got was their PACU order set is what I got.

Q And did that provide you with any basis for your opinions in the case?

A It did.

Q What specifically?

A Relating to the administration of oxygen.

Q What specifically about the administration of oxygen?

A That oxygen was to be administered to patients upon a physician's order and when indicated and to maintain certain saturations.

Q And did you -- do you believe that oxygen was not used in the PACU?

A It was my understanding, by reading the deposition, that oxygen was not used in the PACU.

Q And what is your understanding from reading the depositions regarding the ability of the

A 2000 -- probably '4, I'm thinking through 2005, 2006, when I was a resident.

Q 2004 through 2006?

A Probably so, yeah, about.

Q And about how many of those procedures -- or we can even broaden it to adenoidectomy, tonsillectomy, any type of throat surgery on a pediatric patient?

A Probably in excess of fifty.

Q In 2012 and the year preceding that, 2011, you did not do any of those procedures, though, correct?

A What do you mean?

Q In 2011 and 2012, you did not put any pediatric --

A No, sir.

Q -- patients to sleep, did you?

A No, sir.

Q Have you ever put together a twelve-year-old boy that weighed 81 kilos for a pediatric ...

A Sure, I have.

Q Okay.

A Yeah.

Q And you consider yourself an expert in

what fields of medicine?

A Anesthesia, cardiac anesthesia, critical care anesthesia, echocardiography.

Q Anything else?

A I'm program director of ECMO. So I don't -- that's E-C-M-O. There's no "h" on it.

Q Oh, got you. That's right. Don't pay attention to my notes. I've got terrible note-taking skills.

The opinions that you expressed in this case are also -- you're giving opinions about the standard of care for an ENT physician. Do you believe that you have expertise in that field?

A I don't recall giving an opinion about the practice for an ENT physician. I gave an opinion about the practice of a physician who saw a patient in distress or in an abnormal position. No comment about his practice as an ENT surgeon.

Q What is the -- been the nature of your practice, primarily, since you came to Vanderbilt? Can you just give me a thumbnail sketch of what your years are like?

A I'm sorry. I don't --

Q Do you see patients -- as an anesthesiologist, you don't have clinic patients, do

Q Have you had any firsthand contact with the parents?
A I have not.
Q Have you talked with any other physicians about the facts of this case?
A I have asked another -- I've asked a pediatric anesthesiologist her opinion regarding a prone position in a post-recovery that had changed. And that's about it.
Q Who was that?
A Hold on a second. I'll tell you right now. Heidi Smith, Dr. Heidi Smith. You put me on the spot.
Q And, again, what did you talk to her about?
A I specifically asked her about positioning in the postoperative recovery patient. She had no other facts of the case, just --
Q What did she have to say?
A That she would never routinely allow a child to go prone, of his size.
Q What about semi-prone?
A A semi-lateral position?
Q (Nods in the affirmative.)
A That is completely -- that's called the

recovery position, but in a prone position, in a knee-to-chest, no.

Q Did you bring your medical records with you today?

A I did not.

Q Have you had -- are you reviewing any other cases as an expert witness right now?

A I was asked to review a case one week ago. I just got the records.

Q What -- by whom were you asked?

A One of my senior partners is a physician that has done previous medical/legal work and referred the patient -- or referred an attorney to me in regards to something that I do frequently.

Q And is that a case that you're being asked to review on behalf of a patient or on behalf of a doctor?

A I actually don't know who -- they didn't tell me. They just gave me the -- all they asked me to do is look at these records, and I'm looking at the records.

Q Does it involve a child?

A It involves an adult.

Q Do you advertise yourself as being available to be an expert witness?

Q Did he simply send you the -- did he send you the complaint?

A No.

Q Just the medical records?

A As far as I remember, he sent me the medical records.

Q Other than the report that we've referenced here under Exhibit 6 that you did, did you make any other reports in this case?

A No, sir.

Q Were you asked to sign any affidavit or anything of that nature?

A I think so. I don't think I sent it. I think that's the report, right?

Q Okay. Let's talk about this case specifically now that we've gone through all of that. Give me a brief summary of the facts that you think are significant to this case.

A Brett was a twelve-year-old boy with, I think, some learning issues, developmental issues, that presented for a tonsillectomy/adenoidectomy to Le Boneur Children Hospital. He had a known history, by report, of symptoms consistent with sleep apnea, specifically snoring and gasping breaths.

His physical exam was consistent with

someone who would have sleep apnea and put him at high risk. If I recall right, he had some mention that he had asthma or wheezing as a child, and he was on a nebulizer and took a bronchodilator.

He underwent a tonsillectomy and adenoidectomy under general anesthesia using an endotracheal tube, using an inhalation induction, you know, with a peripheral I.V. placed.

He had 200 milligrams of propofol, 100 milligrams of Lidocaine, 100 micrograms of fentanyl, with a sevoflurane induction, starting off at 8 percent, and titrating down to about 3 percent.

His initial heart rate prior to induction was about 70 and his baseline CO2, after intubation, was about 40, with tidal volumes of about 450, of which are consistent with normal tidal volumes for a patient his size.

At the completion of surgery, he had received no neuromuscular blocking agents, so that was not an issue. He had an end-tidal CO2 that had progressively risen through the duration of the case with tidal volumes that were down to in the 160s that are not consistent with adequate minimal ventilation for a child his size.

He was taken to the recovery room. He

never awakened and really fully emerged, by reports of the parents. He did have emergence delirium, which would be consistent with him thrashing around and moving in an uncoordinated fashion, knocking his monitors off, but that's not consistent with adequacy of respiration, ventilation, or the ability to support one's airway.

While in the recovery room, his oxygen saturation was read as normal. There were some issues with the finger probe maybe falling off. There, some concerns were raised by the parents.

At one point, the surgeon came by and saw the patient laying prone, knee-to-chest, with his face down, and asked the parents if that's how he slept and did nothing to correct the patient's obviously poor position after a tonsillectomy and adenoidectomy.

And shortly thereafter, if I remember right, at about 12 o'clock, the patient has a Code Harvey, which is their cardiac arrest called in the PACU. And Kish turned the patient over to evaluate him when she noticed that he was not snoring anymore, which the patient --

At that point in time, CPR was started. He was intubated at, if I recall right, 12:04 p.m. A blood gas that was drawn approximately fifteen minutes

later showed an arterial CO2 of 96. One done about five minutes before that showed a venous CO2 of "unmeasurable," in excess of 130. Normal arterial CO2 is 40 or so. Normal venous CO2 would be about 45.

Both of these, lab data and the Anesthetic Record, were consistent with a patient who had inadequate ventilation that led to hypoxemia and to his cardiac arrest.

He subsequently was taken to the ICU where he was cared for then. The lines were placed for monitoring and for medicine administration. And over a period, I think, of about 48 hours, which is pretty consistent with assessing brain death, he had multiple tests, including an echocardiogram; I think a blood flow study to look at his brain; and he was declared brain dead.

I think the organ donation center was contacted, but I'd want to say that they refused any visceral organs. They might have done skin and bone.

Q Any other facts that you found significant?

A The other facts that I did find as significant and relevant to the case is the way the patient was monitored in the PACU. Nurse Kish was noted to be on Facebook and using the computer. And

would be -- it depends on the timing. You know, I think this child was not fully awake, based upon my review of the records, when he exited the operating room.

So, you know, he was clearly very hypercarbic, and this had been going on for a while. And so that would be somewhat speculation on my part, and I'm not willing to speculate. I'm only commenting on what I saw present, based upon the medical records and my opinion.

Q Have you seen any toxicology reports or lab reports that would indicate that the patient still had anesthetic in his system at the time he expired?

A I don't remember if there was a toxicology report. The interesting thing about both Sevoflurane and Isoflurane -- and this child received Sevoflurane, which is an inhaled anesthetic -- is that it works by being absorbed. You breathe it and then it goes into the blood, but before it can actually have any effect, it has to go into the brain.

So something called the blood-fat solubility is very important. And your brain has a lot of fat in it because your neurons are surrounded by lipid -- lipid membranes, and so it's impossible to monitor that. There's no toxicology report that would

show that. So we don't monitor Sevoflurane levels.

What you do see -- and that's pretty well-documented that Sevoflurane actually is around for quite a while. The child clearly received Fentanyl -- that's documented in the Anesthetic Record. 100 micrograms, which is about 1.2, 1.25 mcg per kilo for this child, is enough even for a child his age with obstructive sleep apnea to lead him to have significant respiratory depression in the postoperative period.

The Sevoflurane definitely would cause him to have what his anesthetic record demonstrates, which is a rate of about 22 -- a respiratory rate of about 22 and tidal volumes that are small. And that's very consistent with a volatile anesthetic still laying around.

And the issue with having low tidal volume, such as that, is that there's a certain amount of what we call dead space within your lungs. In order for the air to get from here to your alveoli, where you have gas exchange, it's about 150 cc's. 2 cc's per kilo, actually, is what the norm is.

So even in Brett's situation, you would use his height and not his weight to make that determination. So we'll say about 120 cc's for him.

That -- 120 cc's of that does not

participate in gas exchange, so his effective tidal volumes were only 100 cc's, which is consistent with the medical record that clearly shows that he was quite hypercarbic at the time of his arrest, and that of --

You know, there's only so much space in your lungs, and a large portion of that is taken up by nitrogen, which is the most common gas in the atmosphere. And then when you become very hypercarbic, that CO2 actually will displace the available oxygen in your blood.

So when we give supplemental oxygen, we've trying to displace the nitrogen and just overcome any hypoxemic effects. The hypercarbia is still there. It still makes you -- it still depresses your respirations further. It still makes you much more sleepy. And if you look at Brett's anesthetic record, he had a end-tidal CO2 of 54, if I remember right.

Right before that was the last documented CO2. It could have been higher than that. And I think there was a comment on one of the expert opinions that this is not accurate. It can underestimate, but it doesn't ever overestimate your CO2 in your blood.

And a CO2 of 54 by end-tidal -- there's something called physiologic dead space. And so his

arterial CO2 at that point in time was usually no less than 6 higher, so it was at least 60. If you get a CO2 of 80, on most adults and children, you get what we call 1 "MAC" of anesthetic. It's enough sedative potency to actually -- to operate on you. Okay. So Brett was not far from that when he left the operating room, and he had that much CO2.

So to get back to the answer to your question, there's no way to monitor Sevoflurane concentrations that we do in common clinical practice. There's research ways that you can do that, and they have shown that Isoflurane, for instance, will stick around for about 96, sometimes 72 hours. You can still smell it frequently as patients come out. That balto agent [phonetic], that risk for a depression effect, is still present, though not measured.

Q End-tidal CO2 volumes change from second to second?

A It changes from not necessarily second to second, but it can change over periods of breaths. But, you know, for Brett, there was a clear marching up of his CO2. It just wasn't an isolated monitoring.

And I think one of your expert witnesses made that comment that -- you know, "this isolated measurement." Brett's was not isolated. It was --

there was a clear pattern. I mean that's what the data clearly shows, is that this child had an increasing CO2 end-tidal, which would correlate with an increasing arterial CO2, so inadequate ventilation with lower tidal volumes.

And that is part of the instruments that we use to fly the plane. You know, there's definitely a clinical judgment that goes along with this, but it would be -- I guess the analogy would be that, you know, Jimmy Doolittle flew an airplane to Japan and completed a mission with a map and a compass, but you wouldn't get onto an international 747 and not expect the pilot to use the GPS to get you from here to Europe or from here to Atlanta, whichever.

Q Do --

A Then so those monitoring systems, they have to be tied in with clinical judgment, and you can't just ignore those, and that was clearly there.

Q Do you believe that Dr. Paidipalli ignored the diagnostics?

A He either ignored it or should have or could -- he should have done something about it. So I don't know if he just said I don't care. I can't read his mind. But the data is clearly there.

The end points from making the decision

to extubate that child clearly were not supportive of that care. And a reasonable anesthesiologist given the set of facts for Brett, in his physical condition, that's well-documented by the Pre-Anesthetic Record, clearly support the outcome. But it's an expected outcome. It's not a surprise at all, taking the set of facts and the anesthetic that was delivered to that patient.

Q The decision to extubate a patient and wake them up, is that based solely on what the monitors say?

A No, no. There's a lot of different points. So, you know, the first point is to decide whether or not you're going to do -- especially for ENT surgery, there's, you know, one of the -- probably the single largest complication with T&A's is actually bleeding postoperatively. That's the most common concern.

The second most common concern is loss of airway, which actually bleeding can cause loss of airway for -- what happens is blood gets in your airway and it gets on your vocal cords. And your cord spasms. Children are at high risk for this.

And so the decision point in this is a debated way to do it, and there's actually studies that

look at do you do an awake extubation so you have the child fully awake and they are completely with it and interacting with you, and it's, you know -- or do you keep them deep anesthetized, pull the tube out, and then stay in the room longer, let the gas, inhaled agent, go down enough for them to support and maintain their respirations, and then -- you know.

And sometimes you would even bring that patient to the recovery room in that state and you would stay with them and monitor them, one of -- either the CRNA or the physician would stay with the patient while they were monitored until they, you know, arouse and make sure that they are appropriately monitored.

Both -- both -- both decisions are reasonable choices, and there's actually studies that show the benefits of one and the benefits of the other, and that's a clinical decision that you make.

And I can't argue with that clinical decision, but if you're going to do either one, whatever that choice is, you have to do it in a medically acceptable way, and that medically acceptable way could be done in Nashville, Tennessee or Memphis or Alaska, for that matter, but there are certain physiologic variables about giving anesthetics that don't change.

There's judgment calls and then there's "I'm ignoring the available monitoring I have." And those are two separate points.

Q Do you know what the CRNA that handed the patient off to Nurse Kish informed her about?

MR. LEDBETTER: Object as to form. Also, it's a double question.

BY MR. GILMER

Q Do you have what the -- do you have any idea what the CRNA that transferred the patient to the PACU reported to Nurse Kish?

A I didn't see any documentation of what she did or did not. There was some mention that -- I think in one of the affidavits I saw that the circulating nurse, maybe, brought the patient to PACU, and not Kish, so -- but, I mean -- not Kish, but the -- I can't remember her name, the CRNA -- that one of them brought -- so I'm not aware of the hand-off. And there -- there's no documentation that I could find of what exactly that was.

Q If the patient was delivered to the PACU with supplemental oxygen, would that change your opinions in the case?

A If the patient was delivered -- it would make me think that the patient received oxygen, but it

wouldn't change my opinion to the fact that the patient was extubated at a point when he was having inadequate ventilation to support himself and that the end point of him getting hypercarbic and developing respiratory failure and subsequent hypoxemia were inevitable unless something else was done about it. The point to impact that was in the operating room before he ever left the operating room, so --

Q So the decision -- are you saying that the decision to extubate led to the respiratory failure some ninety minutes later?

A Absolutely, no doubt about it.

Q And there was no -- what clinical indications or monitoring indications do you have from the PACU that the patient was having difficulty ventilating?

A Two. Probably the most important one is tachycardia, which is -- you know, is -- can be caused by hypercarbia. Tachycardia in a infant can be -- or a child; he's not an infant -- or an adult can be caused by a variety of things.

This -- Brett received a medicine called Glycopyrrolate, which does tend to increase your heart rate, and he just had surgery, which are two things that can cause your heart rate to go up. So can

hypercarbia.

So it's hard to differentiate that out. They do not monitor end-tidal CO2 in the PACU routinely, and I didn't see any record that they did it there.

There's some issues with the accuracy of CO2 as measured by me breathing through a mask or a nasal cannula as versus an endotracheal tube as -- which was the measurement that Brett had, because they used a 6.5 endotracheal tube that was cuffed for him, which would make the end-tidal CO2 very accurate. And so they didn't -- you know, once the tube was removed, that's -- you know, we don't have any more data points for that.

The other issue is that Brett clearly had what we call emergence delirium, and that is actually pretty common with kids. That's basically what you and I might say you're awake but you're not cognizant and you're not able to make rational decisions. You'll swing at people. You will often obstruct your airway. You can't control your airway. You can't breathe -- you might breath a little bit, but it's -- you know, we see this in adults all the time.

Children are much more prone. So they're -- the amount of attention you have to pay to

this in a child is dramatically more, especially a twelve-year-old child that weighs 80-something kilograms, who has obstructive sleep apnea, like I said, and is getting his tonsils done. It is dramatically higher.

So when patients -- you know, one of the primary things that, as a pediatric anesthesiologist, you have to rule out is hypoxemia and hypercarbia. I mean that is very clear. That's one of the first things you have to do.

And, you know, oxygen saturation monitors are specific but not very sensitive, and the difference is that they are telling you the saturation of hemoglobin -- of oxygen and hemoglobin. Okay. So if when we talk about -- when we're looking through the labs, we have something called PaO2, which is the partial pressure of oxygen within the blood. Well, that -- there's a -- you know, there's a relationship between the two, and they are not linear. And that's why oxygen saturation monitors are not a -- not a very specific monitor of hypoxemia.

So if your PaO2 is 300, your sats going to be 99 percent. Well, if your lung function is down or you're hypercarbic and you're not ventilating well and your CO2 is up to maybe 100, and that CO2 of 100 is

causing you to get more respiratory depressed and not breathing even more, your PaO2 may be down to 75 or 80, and your saturation will still be 99 percent.

So the monitoring devices that we use have their limitations, and that's an important part of what we do as anesthesiologists is ensuring, in spite of those limitations, that we're making the appropriate assessments of the patient, which includes specifically physical exams.

Q And that is also why it's important for the PACU nurse to monitor the patient carefully?

A Agreed.

Q I want to go through and --

MR. GILMER: Well, how much more have you got?

VIDEOGRAPHER: This would be a good time to take a break.

MR. GILMER: Okay.

VIDEOGRAPHER: I've got about twenty-five minutes, but --

MR. GILMER: Oh, I mean I can keep going. I can keep going for twenty-five minutes, if that's all right. I'll grab the medical record here.

BY MR. GILMER:

Q The Anesthesia Record --

A Yes, sir.

Q I would like for you to go through the Anesthesia Record and explain to me exactly what ...

A Okay. You want me to just go through it, or do you have a specific question you --

Q No, I -- yeah, I would like for you to go through specifically the issues that you've just discussed regarding the hypercarbia.

A So may I share your pen? So as you can see here [indicating], Brett came into the operating room and he was put on nitrous, which is laughing gas and air, 7 liters, amended in 3 liters -- an amendment which is a normal way we induce a child -- and then Sevoflurane, 8 percent. That's the maximum amount of Sevoflurane.

So you're trying to, very quickly, get the child -- but you don't have I.V. access. And then once you get I.V. access, then they gave Robinul, which is a medicine that prevents children from getting their heart rate down a lot in -- so you see that. At the same time, his heart rate, which is this dot here [indicating], kicks up from 80 to 110, which -- the good news about Robinul is it prevents the brachycardia, but it also hides signs of hypercarbia, such as tachycardia, because you don't know what that's

A Because if he's uncomfortable, then he's going to be delirious, too, if he wakes up hurting.

Q Do you have any opinion concerning the documentation that Dr. Paidipalli made?

A This chart is primarily done by the CRNA, and the only thing that he did was this portion right here [indicating] as -- you know, based upon the handwriting, looking at it. I'm not aware of any other documentation that I saw other than the pre-op anesthetic assessment, and that was uninterpretable.

Q Do you have any criticisms of the documentation made by the CRNA on this Anesthesia Record?

A The documentation seems fine. The medical decisions do not.

MR. GILMER: Okay. Let's mark the Anesthesia Record as the next numbered exhibit.

(Anesthesia Record marked as Exhibit No. 7 to this deposition.)

BY MR. GILMER:

Q And, Doctor, for the record, the blue ink that is on here, you just made, correct?

A Yes, sir.

MR. GILMER: Okay. Why don't we take a break?

VIDEOGRAPHER: This is the end of Disc No. 1. The time is 3:07.

(Recess taken from 3:07 to 3:15 p.m.)

VIDEOGRAPHER: This is the beginning of Disc 2 of the deposition of Dr. Jason Kennedy. The time is 3:15. You may begin.

BY MR. GILMER:

Q Doctor, we had just went through the Anesthesia Record and talked about your -- the bases for your opinions. What, in your opinion, did the standard of care require of Dr. Paidipalli to do rather than extubate the patient at 10:26?

A To allow the patient's spontaneous respiratory drive to return to normal and to assist him into that point.

Q And how would he have done that?

A By keeping the breathing tube in and assisting his ventilation via the anesthetic machine as a way you can manually support his breathing, or you can put him back on the ventilator that's incorporated into the anesthetic machine.

Q This use of supplemental oxygen was not sufficient?

A No, because supplemental oxygen can actually kind of hide that hypoc -- low tidal volume

ventilation that you see. It might have prevented him de-saturating, but it wasn't going to prevent his eventual outcome.

Q The -- at the bottom right-hand corner here, it talks about the -- what does this say, "ICU/PACU at 10:35"?

A Yeah. That's either ICU or the Post-Anesthesia Care Unit at 10:35 versus 10:36. I don't know if they were in the unit at 10:35 and did that at 10:36. And these are the vital signs.

Q Okay. And what do -- do the vital signs indicate anything to you?

A Nope.

Q Anything abnormal?

A He's a little tachycardiac, which means he has a fast heart rate at 118. His respiratory rate is 22, which is a little fast. And in someone who was agitated and delirious, it would make me -- you know, were trashing around in the bed or removing things, it would make me very concerned that they are actually hypercarbic.

Q But being -- thrashing around or emerging --

A Moving.

Q -- at that point, that in itself, can't

that make you tachycardiac?

A Yeah. So can the glycopyrrolate, but the combined picture -- so taking one single vital sign out of -- out of context, can get you into trouble. But if you take the totality of the data that's present, it's very clear what happened to him, and this was foreseeable coming out of the operating room.

Q Let's go over your report that you did in the case.

A Yes, sir.

Q That's your copy [indicating], and I'll use his copy. The first paragraphs have to do with your background. Let's see, it shows what you have reviewed. And we've talked about what you've reviewed. Did the photographs of Brett help you form any opinions in the case?

A Yeah, it did.

Q How so?

A The fact that he was in a position that I would not consider consistent with the standard way I would position a post-tonsillectomy patient of Brett's size and body habitus.

Q What did the standard of care require as far as the positioning of the patient?

A You can do it in a lot of different

ways. You could be supine with the head elevated, which according to Kish was a common thing. You could be in what they call the semi-lateral position with your head slightly elevated with the -- basically kind of sleeping on your side to allow some of the secretions to come out. That would be reasonable.

The knee/chest position, being completely prone -- I've seen that, and I've done that before with young babies, young children, but they are so much smaller, and the weight, their total body weight, is less of an issue, laying on their diaphram, as in Brett's case, who was 82-, 81-kilos, not -- I've never done that with an adult before.

Q With -- when you say prone, Brett's face was turned to the side, though, correct?

A As best as I could tell in the picture, he was face down and -- but it was -- I mean it was a picture. And that's -- and that's the best I have. And I think there were statements made by Kish about him being, you know, face into the gurney.

Q And she had the ability to change that position or notify someone about any concerns that she had about that position?

A As did the ENT surgeon, yes.

Q Now, why do you believe that you're

familiar with the standard of care for an anesthesiologist practicing in Memphis, Shelby County, Tennessee, in March of 2012?

A Specific to what? What?

Q Well, specifically with your opinions to this case. Why do you believe that you're familiar with the standard of care from Memphis when you have not practiced there?

A Based upon what Dr. Paidipalli's and Dr. Kish's [sic] statements were, doing what they normally did at the children's hospital, and in line with what is normally practiced for anesthetic practice throughout the rest of the country.

Q Do you believe that the standard of care that you are applying is a national standard of care?

A I think there are certain aspects of it, yes, and some of it regarding, for instance, the administration of oxygen or being in a prone position, I'm basing upon the statements that both the ENT surgeon, the anesthesiologist, and Nurse Kish said what was normal and customary in their practice.

Q And so that would be the same for any anesthesiologist practicing anywhere?

A There might be subtleties about whether or not you give oxygen to patients, but, you know, what